ZRC MEDICAL RESOLUTIONS INC

REVIEWER'S REPORT

DATE OF REVIEW: 03/19/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OF SERVICES IN DISPUTE:
Occupational therapy/physical therapy, three times a week for four weeks

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:
M.D., board certified orthopedic surgeon with extensive experience in the evaluation and treatment patients suffering wrist injuries

REVIEW OUTCOME:
"Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

__X __Upheld (Agree)

_____Overturned (Disagree)

_____Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED FOR REVIEW:
1. forms
2. TDI referral forms
3. Denial letters, 02/15/10 and 02/24/10
4. URA records
5. Preauthorization request times two
6. Therapy prescription, 02/04/10
7. Clinic notes, 02/04/10
8. Physical therapy evaluation, 01/21/10
9. Insurance company notes to the file, 05/20/09, 07/08/09, 04/10/08, 07/24/09, 08/18/09, 09/15/09, 12/29/09, 02/09/10, 02/16/10, 06/06/08, 08/13/08, 09/04/08, 10/31/08, 12/02/08, 04/02/09, and 05/18/09

INJURED EMPLOYEE CLINICAL HISTORY (Summary):
This unfortunate female waitress suffered a wrist injury on xx/xx/xx while carrying a. She felt a pop and pain in her left wrist. A diagnosis was made of TFCC tear and ulnar

carpal abutment syndrome. She underwent an ulnar shortening osteotomy on 03/31/09 and subsequently underwent approximately 26-30 sessions of physical therapy. The current request for physical therapy is to continue therapy for her cervical and shoulder pain. The request has been considered and denied, reconsidered and denied.

ANALYSIS AND EXPLANATION OF THE DECISION, INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT DECISION:
The clinical records are limited. The most recent clinical evaluation dated 02/04/10 reveals that the left wrist was "doing fine." Additional physical therapy does not appear to be related to ongoing problems with the left wrist. The patient has received an appropriate regimen of physical therapy in the postoperative circumstances after the ulnar shortening osteotomy and the debridement of the TFCC tear. The prior denials were appropriate and should be upheld.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR DECISION:
(Check any of the following that were used in the course of your review.)

_____ACOEM-American College of Occupational & Environmental Medicine UM Knowledgebase.
_____AHCPR-Agency for Healthcare Research & Quality Guidelines.
_____DWC-Division of Workers' Compensation Policies or Guidelines.
_____European Guidelines for Management of Chronic Low Back Pain.
_____Interqual Criteria.
__X __Medical judgment, clinical experience and expertise in accordance with accepted medical standards.
_____Mercy Center Consensus Conference Guidelines.
_____Milliman Care Guidelines.
__X __ODG-Official Disability Guidelines & Treatment Guidelines.
_____Pressley Reed, The Medical Disability Advisor.
_____Texas Guidelines for Chiropractic Quality Assurance & Practice Parameters.
_____Texas TACADA Guidelines.
_____TMF Screening Criteria Manual.
_____Peer reviewed national accepted medical literature (provide a description).
_____Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)